

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046235

STATE FILE NUMBER

FILED JAN 6 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12137

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before a. STATE MO. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 27 7213a Balson	
3. NAME OF DECEASED (Type or print) First Middle Last SAM ROSENFELD		4. DATE OF DEATH Month Day Year Dec. 16, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unk
9. AGE (In years last birthday) ab. 74		10. USUAL OCCUPATION (Give kind of work done during most of life. If retired) Cabinet maker	11. BIRTHPLACE (City and state or country) USSR
10a. USUAL OCCUPATION (Give kind of work done during most of life. If retired)		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Unk. Rosemfeld		13b. MOTHER'S MAIDEN NAME Fannie Unk.	14. NAME OF HUSBAND OR WIFE Sarah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 497005-7625	17. INFORMANT Address Sarah Rosenfeld 7213a Balson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>mycosis fungoides</i> DUE TO (b) _____ DUE TO (c) <i>205X</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Carcinoma of Larynx. arteriosclerotic Cardiovascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>Nov. 7, 1958</i> to <i>Dec. 16, 1958</i> and last saw <sup>her</sup> him alive on <i>Dec. 16, 1958</i> Death occurred at <i>9:20 a.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Caron Birenbaum, M.D.</i>		22b. ADDRESS <i>462 N. Taylor</i>	
22c. DATE SIGNED <i>12/16/58</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12/17/58</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Chesed Shel Emeth</i>		23d. LOCATION (City, town, or county) (State) <i>University City, Mo.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Berger Memorial 4715 McPherson</i>		25. DATE RECD. BY LOCAL REG. <i>DEC 16 '58</i>	
26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>m &amp; B.</i>			

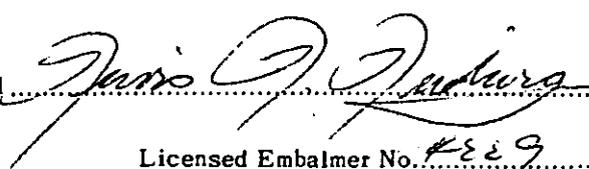
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. 4229 .....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.